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ABSTRACT

Anorexia nervosa has received considerable attention lately because of its increased incidence, potential danger, and resistance to treatment. A review of the literature on anorexia nervosa suggests that, although it is characterized by complex interrelated psychological and physiological processes, it is often conceptualized and treated in unifocal or unimodal terms. Even when more eclectic, multi-dimensional orientations are employed, they fail to provide a conceptual framework or a systematic approach. Perhaps for these reasons, treatment effects have been circumscribed and relapse rates high. The multimodal therapy model of Arnold Lazarus obviates many of the deficits cited, in offering a comprehensive, systematic, holistic approach to assessment and treatment. This multimodal approach focuses on the areas of behavior, affect, sensory, imagery, cognitive, interpersonal, and drugs. Therapy methods include identifying the triggering modalities, "bridging" the client from one modality to another, and tracking the intervening modalities. A multimodal case study employing the Lazarus method for an adolescent anorexic girl is discussed. (ABL)

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Multimodal Therapy for Anorexia Nervosa: An Holistic Approach to Treatment

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ABSTRACT. A review of the literature on anorexia nervosa suggests that, although it is characterized by complex interrelated psychological and physiological processes, it is often conceptualized and treated in unifocal or unimodal terms. Even when more eclectic, multi-dimensional orientations are employed, they fail to provide a conceptual framework or a systematic approach. Perhaps for these reasons, treatment effects have been circumscribed and relapse rates high. This paper purports that the multimodal therapy model of Arnold Lazarus obviates many of the deficits cited, in offering a comprehensive, systematic, holistic approach to assessment and treatment. A multimodal case study of an adolescent anorexic girl is discussed.

Anorexia nervosa has received considerable attention of late because of its increased incidence, potential danger, and resistance to treatment. It is clear from a perusal of DSM III that the condition is characterized by complex interrelated psychological and physiological processes: refusal to maintain normal body weight, loss of at least 25 percent of original weight, distorted body image, fear of obesity, lack of an accountable medical condition, and amenorrhea in females. In addition, a variety of other behavioral, emotional, and cognitive characteristics have been identified as common to the disorder (Crisp, 1980). The multi-dimensional status of the condition notwithstanding however, its etiology and treatment have often been discussed in unifocal or unimodal terms (Geller, 1975). Psychoanalytic theory relates the anorexic's eating behavior to psychosexual immaturity, the physical and psychological symptoms being explained as products of oral ambivalence and as a defense against oral impregnation fantasies (Sours, 1974). Family therapists focus on what

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they perceive to be pathological needs within the family which are primary in precipitating and maintaining anorexia (Rosman, Minuchin, & Leibman, 1975). Behaviorists explain the disorder in conditioning terms, food rejection being positively reinforced by attention (Allyon, Haughton, & Osmond, 1964), or as a form of avoidance behavior (Leitenberg, Agras, & Thomson, 1968). Medical practitioners emphasize physical abnormalities, theorizing that anorexia may result from cerebral override of normal hypothalamic function or from a defect in the regulatory mechanism itself (Greenwood & Johnson, 1975). It should be noted that a number of other specific explanations have been advanced—perceptual (Slade & Russell, 1973), sociocultural (Boskind-Lodahl, 1976), cognitive (Garner & Bemis, 1982).

As would be expected, adherents to a particular etiological or theoretical position tend to treat their clients in accord with their unimodal conceptualizations. Thus assessment and treatment methods address only those limited factors that are viewed as central to the position accepted. It is perhaps such narrowness of approach that has resulted in the high relapse rate among anorexics (Garner & Bemis, 1982). As Bemis (1978) has stated:

> It is unlikely that any theoretical system will ever account for all aspects of this disorder on the basis of a unifocal approach to etiology or treatment . . . The contributions of all areas must be incorporated into an understanding of anorexia that recognize multiple factors of causation and utilize a range of treatment modalities. The treatment of anorexia appears to be evolving towards a more integrative and eclectic approach, and recent contributions of research in many areas appear promising. (p. 614)

The conclusion by Garner and Bemis (1982, p. 125) that "anorexia nervosa is at this time best considered a multiply determined disorder, both within and between individual patients," has lent additional support to the need for an eclectic approach. However, eclectic treatment has generally resulted in practitioners employing a variety of therapeutic approaches in a somewhat "shot gun fashion." For example, Geller (1975) employed psychotherapy and behavior therapy; Garfinkel, Garner and Maldofsky (1977) used behavior therapy, individual psychotherapy and family therapy; Ollendick (1979) utilized systematic desensitization and cognitive restructuring; Garner and Garfinkel (1980) implemented individual, family and behavior therapy; Horne (1980) employed behavior contracting, family therapy, cognitive therapy, chemotherapy, hypnotherapy and individual psychotherapy; Garner and Bemis (1982) used behavior and cognitive therapy; and Silber and Bogado (1983) implemented a multitherapist approach (pediatrician and psychiatrist), in ad-

dition to individual and family therapy, behavior modification, and a nutrition program.

It is important to note, however, that none of these "multi-dimensional" approaches provide a conceptual framework for organizing the various characteristics of the disorder; none provide a systematic approach to assessment and treatment, identifying specific treatment strategies for specific symptoms; none provide guidelines for determining the order of treatment, for dealing with inertia or preventing relapse. A therapeutic model that does attempt to obviate the problems identified above is the multimodal therapy of Arnold Lazarus (1973, 1976, 1981).

Lazarus formulated the multimodal model of treatment after his systematic follow-up studies of therapy cases revealed that relapse occurred far more frequently than practitioners realized. Upon investigating the reason for this, it became clear that most people in therapy failed to acquire a significantly broad range of coping skills, which would enable them to deal effectively with the multiplicity of life's demands. It appeared that most therapeutic methods were often singular in their approach to the definition of the problem (basic anxiety, poor self-concept, repressed hostility, etc.) and in their treatment techniques (insight, catharsis, conditioning, etc.). In place of a unimodal orientation towards assessment and treatment, Lazarus has argued for a multimodal approach which focuses on seven modalities or problematic areas: behavior, affect, sensory, imagery, cognitive, interpersonal and drugs (biological). Successful therapy necessitates that each of these human dimensions be attended to in an integrative, holistic manner. The acronym BASIC ID is used to denote each of these modalities.

In addition to the assessment strategies that would be employed in any therapeutic relationship, the multimodal model identifies several methods that are unique. For example, "firing order" enables the therapist to determine which of the modalities triggers the sequential chain of events and thereby which treatment method has the best chance of being successful; "bridging" allows the therapist to skillfully maneuver the client from his/her preferred modality to the one in which the therapist has detected resistance, without lessening rapport; "tracking" helps the client to monitor the interactive affects among the modalities and thereby intervene at strategic points. The use of the structural profile, second order Basic Id and the Multimodal Questionnaire are additional assessment devices. The case study to be detailed in this article employed several of these techniques.

The use of multimodal therapy for anorexia nervosa seems indicated due to the condition's complex symptomatology, which involves several modalities, as well as the variety of causative factors that have been identified in etiological studies. Dysfunctional behaviors, emotional disturbances, problematic sensations, distortions in imagery and cognitive

processes, deficits in interpersonal skills, and severe physical and physiological abnormalities (many of which are interrelated) are all considered characteristic of the anorexic condition. The development of multimodal profiles for each client insures that the idiosyncratic manifestations of anorexia nervosa are identified, thereby lessening the clinician's tendency to formulate generalized treatment strategies which are, perforce, ineffective. In addition, by emphasizing the acquisition of coping skills, multimodal therapy attempts to decrease the chances of relapse.

CASE STUDY

Background

The client, Mary, is an attractive thirteen year old girl who developed anorexia nervosa near the end of her sixth grade school term. She had been abandoned by her mother at a public swimming pool at the age of 7. Prior to being deserted, her childhood was marked by considerable neglect. She lived "gypsy style" with her family in a truck, her schooling was sporadic, food and clothing were scarce and, in addition, there was evidence that she had experienced both physical and sexual abuse.

After her abandonment Mary was placed in a childcare institution for approximately one year. She then began living with a foster family with whom she resides at the present time. Her adjustment in that home has always been viewed as problematic, with an increase in negative behavior noted after the court termination of the rights of her natural parents. Individual and family therapy were effective in reducing Mary's acting-out behavior and in improving family interactions. As a result of the therapeutic intervention, her foster placement remained intact.

One year later, following the initiation of adoption procedures by the foster parents, Mary began manifesting symptoms of anorexia nervosa (e.g., a decrease in weight from 135 to 84 pounds, amenorrehea, increased activity level, refusal to eat, periods of bulimia, distortions in body image, obsessions concerning food, fear of obesity, etc.). Besides the prospective adoption, other possible precipitating factors included: anxiety regarding her transfer to junior high school in the fall, concern about her weight and the initiation of a diet, comments made by friends regarding the size of her thighs, as well as the suggestion that her natural mother was overweight, and finally, the fact that her foster sister was dieting unsuccessfully at the time.

Assessment

Since Mary had been involved in psychotherapy previously to decrease her acting out behavior in the home, there already was a multimodal therapy plan in effect. However, following the development of her

anorexic condition, it was necessary to draw up a "second order" BASIC ID profile in order to identify and address the dysfunctional aspects of her eating disorder. Outlined below are the various assessment procedures employed prior to and throughout this phase of therapy.

Behavior:	—daily log and self-reports —data on eating behavior and activity level recorded by foster mother —observation of eating behavior by therapist
Affect:	—projective testing (TAT, Projective Drawings)
Sensation:	—self-reports
Imagery:	—self-image assessment (Piers-Harris Children's Self-Concept Inventory)
Cognition:	—projective testing, irrational beliefs sentence completion, questions pertaining to weight, diet, health, etc.
Interpersonal:	—self-reports —reports from family members
Drugs:	—results from physical exams —chart on weight loss/gain

Treatment Method

Initial treatment of Mary's anorexia focused on increasing her body weight to a level that was medically safe and which enabled her to engage in the aspects of therapy that required active participation and concentration. Her foster parents were included in the therapy in order to provide them with strategies for reducing the anxiety they were experiencing, as well as to educate them regarding particular behavioral techniques that were to be implemented in the home. Individual therapy sessions were held with Mary once per week, with an increase in contacts to twice per week during the more acute phases of the disorder. A physician was involved in the monitoring of her physical condition and was available to provide medical treatment and/or hospitalization if required.

Therapeutic strategies were developed to address each problematic aspect of Mary's functioning as identified via the multimodal assessment. The assessment revealed a "firing order" of C-A-B, i.e., it appeared that Mary first experienced some intrusive and dysfunctional thoughts related to food and self-control (C), which resulted in her becoming anxious and angry (A), resulting in inappropriate food refusal, acting out, etc. (B). Thus, the Cognitive Modality received considerable attention during the early stages of therapy, and Mary was taught to monitor the sequential problem development ("tracking") to aid in her own treatment. Her

therapy plan is outlined in Table 1 and a summary of the therapeutic techniques that were utilized follows.

Behavior

The main focus of treatment within the behavior modality was to increase Mary's food intake. Her mealtime was structured and a contingency management system was developed which required her to eat a predetermined amount of food at each meal. Portions were prepared by Mary's foster mother so that they were larger than the desired amount in order to allow for Mary's need to leave some food remaining on her plate. Mary was supervised while eating and for at least 1/2 hour following completion of the meal to insure that the food was ingested and to prevent her

Table 1

Multimodal Therapy Plan for Anorexia Nervosa

Modality	Problem	Treatment
Behavior	1. refusal to eat	1. contingency management & self-monitoring
	2. overactivity	2. daily log, structured mealtime
	3. bulimia	3. self-monitoring, response prevention
Affect	1. anxiety	1. relaxation training, positive imagery
	2. anger	2. anger inoculation emotional venting
Sensation	1. inaccurate sensation of fullness	1. sensory awareness exercises
Imagery	1. distorted body image	1. positive imagery, information about illusions and exercises
Cognition	1. obsessive thoughts related to food, eating, etc.	1. thought stopping, symptom prescription
	2. belief that she lacked control over her life	2. realistic goal setting, problem solving, RET
	3. denial of dangers of weight loss	3. bibliotherapy
Interpersonal	1. negative interactions with family members	1. scheduling of positive family activities
Drugs (biological)	1. amenorrehea, fatigue, weight loss	1. weekly medical examination by physician

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from regurgitating. Whenever Mary ate the required portion of food, she was permitted to choose particular physical activities and/or exercises to engage in during the time period between meals. Participation in physical activities had been found to be highly reinforcing for Mary and the use of these activities as a reward enabled the foster parents to monitor her level of activity more easily, thereby preventing Mary from over-exerting herself.

Mary monitored her own eating behavior, as well as incidents of bulimia through recordings in a daily log. Her data were presented and reviewed during each therapy session.

Affect

Although Mary was experiencing many negative emotional reactions throughout this period, the two most prevalent and disruptive were her anxiety and anger. Since she had been taught progressive relaxation exercises prior to developing anorexia, only a brief review of the techniques was necessary. During this period of time she was instructed to utilize the relaxation procedure on a daily basis and whenever she experienced high levels of anxiety. In addition she was taught to draw upon positive images which also produced feelings of calmness and relaxation (i.e., seeing herself at her ideal weight; picturing herself interacting with her family during a pleasant, happy day; imagining herself alone in a peaceful, tranquil setting, etc.). For those times in which she experienced her anger as overpowering she was taught the steps of an "anger control" program which essentially involved removing herself from the anger inducing situation, utilizing a relaxation strategy to reduce her anger/tension level and then dealing with the problematic situation in an assertive manner.

Sensation

Mary often reported that her aversive reaction to eating was due to the intense sensation of fullness that she experienced whenever she ate even the smallest quantity of food. In order to correct her erroneous sensations, Mary practiced focusing her attention on the sensations in her stomach and discriminating among various degrees of "fullness" (e.g., one grape vs. a sandwich). Once she learned to make such distinctions, she was taught to check the accuracy of the sensations after eating and to review the "discrimination training" whenever she experienced a feeling of "heaviness" in her stomach.

Imagery

Despite her emaciated appearance, Mary continued to perceive herself as "overweight." Therefore, therapy within the imagery modality centered on helping her understand that her body-image could be distorted

and was not necessarily a reflection of her true body size. The main treatment technique involved the presentation of various illusions (Muller-Lyer, Necker Cube, etc.) to demonstrate that perceptions can be inaccurate. In addition, "imagery exercises" were utilized in which Mary contrasted images of herself as "fat," "skinny," and finally at the "perfect" weight.

Cognition

Mary's constant and intrusive thoughts related to food, dieting, weight gain, etc., were one of the few aspects of her anorexic functioning that she identified as problematic and was motivated to change. A "thought stopping" technique was employed in which Mary was taught to interrupt any food/diet related thought immediately as it developed. Also, the scheduling of a time each day during which she was "allowed" to deliberate on these thoughts was included as part of the therapeutic plan (symptom prescription).

Assessment of Mary's fundamental beliefs and her thought processes revealed the presence of several "irrational" ideas and distorted thinking processes. Mary frequently stated that she felt "helpless" and "picked on", that "nothing ever went right", and that she "should be treated better". Discussion of these statements uncovered the irrational/dysfunctional beliefs that problems were externally caused, that she had no control over herself, and that life should be fair (Ellis, 1975). It was also clear that prominent among her distorted thought processes were overgeneralization, filtering, and polarized thinking (McKay, Davis, & Fanning, 1981). The techniques of Rational Emotive Therapy (Ellis, 1975) were used to help Mary alter her dysfunctional thoughts and to learn rational thinking processes. More specifically, she was taught to identify the particular form her irrational beliefs took ("My teacher makes me so angry"; "I can't control my eating"; "My parents should always treat me the same as my sister ") and to catch herself when she was thinking in a distorted manner ("Nothing good ever happens to me"; "My thighs are big and that proves I'm ugly "). Mary was then trained to dispute the underlying irrational beliefs and to replace them with more rational ideas. The same was done with respect to her distorted thinking processes.

In addition, realistic goal setting and problem solving techniques were taught (D'Zurilla & Goldfried, 1971) and then employed to effect positive changes in certain areas of her functioning (social situations, classroom activities, etc.). She was taught to identify a problem, review possible solutions and positive/negative consequences, test each solution against her personal values, apply the solution, and finally to evaluate the results. Positive outcomes served as evidence that she was "in control" of her life to some degree, and that eventually, more control was possible.

Another dysfunctional belief held by Mary involved denial related to the dangers inherent in her rapid weight loss. Bibliotherapy on topics such as anorexia, health dieting, nutrition, etc., was prescribed to correct this erroneous belief in a factual, non-emotional manner.

Interpersonal

Members of Mary's foster family were often the recipients of her excessive anger and verbal aggression. Also, during this time the majority of her interactions with her foster parents focused on issues pertaining to her anorexic condition. Therefore, in order to improve familial relationships and to relieve some of the tension and anxiety, positive activities/outings were scheduled during which time nothing related to anorexia could be discussed.

Drugs/Biological

Mary received regular physical examinations while she was anorexic. Coordination between the physician and therapist on issues such as establishing the appropriate point that, if necessary, hospitalization would occur, deciding on how information regarding her physical state would be communicated to her, etc., was established to ensure continuity of treatment.

Results

As a result of the multimodal therapy plan:

1. Mary's weight increased from 85 to 114 lbs. in the course of 8 weeks.
2. Eating behavior has normalized.
3. Bulimia is no longer in evidence.
4. Distortions in body imagery have been corrected.
5. Extreme emotional responses (anger, anxiety, depression, etc.) have decreased. In general, affect is more appropriate.
6. Tension level has decreased.
7. Obsessive and irrational thoughts have been replaced with more functional beliefs and perceptions.
8. Interpersonal relationships with family members and peers have improved.

Presently, Mary weighs 125 lbs. and has maintained this weight level for almost 1-1/2 years. Within this time period there has not been a reoccurrence of any of the severe symptoms of anorexia. A few incidents of "skipping" meals or partial dieting have been reported, particularly dur-

ing times of stress. However, the reinitiation of the appropriate treatment technique during such times has been effective in alleviating her tension and in reducing the problematic eating behaviors.

Following the cessation of all of Mary's symptoms of anorexia, assessment and treatment continued with regard to additional areas of dysfunction identified within the seven modalities. Also, many of the issues hypothesized to be the precipitating factors in the development of her anorexia (e.g., adoption proceedings, commencement of junior high school, etc.) were explored further. This additional treatment has resulted in a significant reduction in Mary's acting out behavior (B) and excessive anger (A), an improvement in her self-image (Im), a better understanding of past events in her life (C) and the development of more appropriate social behavior when interacting with peers and foster family members (In). Such positive changes have helped to secure the continuation of her foster placement, and the goal of eventual adoption is still viewed as viable. Given the absence of anorexia symptoms for this prolonged time period, and the gains noted in her overall functioning as well as her acquisition of effective coping skills, the prognosis regarding Mary's future adjustment can be considered quite good.

Summary

The benefits of a multimodal approach to anorexia nervosa is clearly illustrated in this case. It enabled the therapist to fit the complex symptomatology into a unified framework, and then to determine systematically, the most effective therapeutic methods for each aspect of the problem. While certain practical concerns necessitated immediate attention to the behavior modality, subsequently the "firing order" helped guide the sequence of interventions. The "second order" BASIC ID enabled the anorexia nervosa to be addressed within the context of the overall treatment model (multimodal), and after success was achieved here, to treat other problems within the same framework. When some minor symptoms reappeared, the multimodal coping skills taught, allowed them to be dispatched fairly quickly, thereby preventing relapse.

In sum therefore, it would appear that the comprehensive, systematic, holistic approach of multimodal therapy has much to offer practitioners in their treatment of anorexia nervosa in particular, and psychological disorders in general.

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